Grove House Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Grove House Practice on 29 September 2015. Overall the practice is rated as good.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice leads on safeguarding were able to show us examples of interventions that had resulted in enhanced safety measures being put in place for those patients who were deemed to be vulnerable. This had sometimes involved GPs challenging decisions of safeguarding boards, when further local knowledge indicated some decisions would need to be reviewed immediately to safeguard the most vulnerable patients.
- The practice used innovative and proactive methods to improve patient outcomes. We saw that the practice used Met Office forecasts for example, for cold weather warnings, to plan for and meet increased needs of those patients with long term conditions. The practice had recently started to trial e-consulting where patients would email the practice with their symptoms and GPs would respond on the day.
- Patients said they were treated with compassion, dignity and respect. We saw how the practice dealt compassionately with patients and did all they could to assist in the support of carers and family members.
- The practice staff and clinicians held regular focussed meetings to ensure that care was 'joined up' and that it continued to meet the changing needs of more complex patients.
- The practice made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). For example, the practice used 'positive action' in recruitment to secure the services of a permanent male practice nurse to help increase engagement with male patients of all ages. The flu season clinics were being used to raise awareness of other men's health issues, for example prostate health.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice had worked extensively with specialist providers outside the area to ensure they supported a very high level of care to younger patients with high dependency and complex needs. We saw how the practice supported families of these patients by being accessible at all times. This was achieved by using a buddy system amongst the GP partners, which meant the patient and their families would see one of two GPs who were familiar with the patients and families needs.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. We saw good examples of joint working with midwives and health visitors who were based in the same building, and with school nurses. Staff shared locally acquired knowledge to keep vulnerable patients safe, especially were this could affect decisions on the future care arrangements of vulnerable patients.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff worked with multidisciplinary teams, which involved staff from care providers and voluntary organisations that could contribute to the long term, effective care and support of patients. Clinicians worked with SCIP workers to provide more holistic treatment of patients, where social factors were significant contributors to some patients' health problems. Data showed patient outcomes were in line with the average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. We saw particularly how clinicians strived to provide continuity of care by use of a buddying system within the

Summary of findings

practice. This was particularly important to those patients with complex needs, their carers and their relatives. Staff worked with all stakeholders to ensure that patient care was compassionate and focused on the needs of the individual.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Where data showed the practice could improve on positive scores for patient satisfaction, we saw plans in place to address this. Urgent appointments were available on the same day. We saw the practice respond to examples of social isolation of patients and the way this affected the health of the local population. To address this the practice had built up a matrix of almost 600 voluntary organisations, many of which were invited to a 'market day' at the practice to reach out to more isolated patients, offering support and well-being services. Practice clinicians worked on a daily basis with SCIP workers, to support vulnerable patients and tackle the root cause of complex health problems of some patients. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the Patient Participation Group (PPG). Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff. Teams worked together across all roles. Governance and performance management arrangements had been reviewed and took account of current models of best practice. The practice had succession planning in place, which was reviewed to ensure that the skills set of clinicians kept pace with the demands of the practice population and the practice desire to offer more integrated care. There was a high level of constructive engagement with all staff. Staff we spoke with spoke of high levels of satisfaction in their role. The practice worked with the wider health care community to deliver care that met the needs of patients. We saw examples of how this was promoted and supported by the leadership team as critical to delivering services that truly addressed patients' health issues. The practice gathered feedback from patients and it had an active Patient Participation Group (PPG) which influenced practice development.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive care to meet the needs of the older patients and had a range of enhanced services, for example in dementia diagnosis and care and remote care and monitoring for patients at risk from long term conditions, such as high blood pressure. It was responsive to the needs of older people, offering home visits and rapid access appointments for those with enhanced needs. The practice had facilitated a 'market day' at the practice recently, bringing together many voluntary and community groups that offered help, support and well-being and companionship services to older people. Social activities were listed under a variety of topics such as men in sheds, singing, swimming and dancing. Monitoring and advice was available on the day for things such as body mass index (BMI), blood pressure and lung function. There was practical help and assistance to help reduce the chance of falls and risks from diabetes. The event was well supported. Practice feedback showed that 100% of patients attending found it worthwhile. The practice has an over 75's working group. The group have met with practice leaders to discuss which initiatives would bring the most advantages to patients. For example, it was discussed as to whether a memory test should be included in the annual health check for older people. The practice had actively started recording when people live alone on patient records. Facilities were in place for older patients to monitor blood pressure at home, were this was identified as a contributory factor to a decline in the health.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice system of each GP having a buddy arrangement provided patients with a greater level of continuity of care, which patient feedback confirmed as being important.

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Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice had a lead safeguarding GP who worked with all partners and clinicians to ensure any safeguarding review board had access to the most up to date information on patients subject to safeguarding plans. Where this was local knowledge which could affect any decision, staff were encouraged to share this so it could be formally documented.

Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors who were based in the same building, and with school nurses. We saw examples of outstanding care provided to young patients with complex needs; this involved a high degree of working and communication with specialist providers outside of the immediate locality. In such cases, we saw how the practice supported the families involved in a responsive and compassionate manner.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had reviewed how effective it was in reaching out to male patients within its population. Following consultation with the Patient Participation Group, the practice recruited a male practice nurse. As this staff member dealt with a large amount of chronic disease management in patients, the practice set objectives for the staff member on opportunistic intervention with male patients to raise awareness on key health issues, for example, some specific male cancers, other more common ailments and early warning signs. From early data we reviewed (from end June 2015) we could see an small increase in the attendance of male patients at health check reviews, but it was still too early to say whether this purely down to the access to a male practice nurse. However, this move did increase the options for male patients to see a male clinician at the practice.

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People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It guided vulnerable patients on how to access various support groups and voluntary organisations. We saw several examples of the practice using a SCIP (Social care in practice) worker to truly address root causes of patients' health issues, particularly those more vulnerable patients. Steps taken included enrolment of patients on alcohol recovery programmes, tackling housing issues and initiation of social care packages that allowed vulnerable patients to live safely in their own home. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had recently reviewed its annual health check to see if a memory test could be incorporated into this to check for early signs of dementia.

The practice guided patients experiencing poor mental health on how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. GP partners were able to give us an example of when they had intervened with a patient experiencing a fast paced mental health crisis, and were able to show how their response to this was safe and effective. The practice also used the example to review how any future incidents involving patients experiencing mental health issues would be handled. Learning points in this example were shared with all staff, increasing their confidence on how to deal with this patient group.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing in line with local and national averages. There were 377 forms distributed to a sample of the 10,500 patients of the practice. Of these, 113 responses were received, giving a response rate of 30%. Results showed that:

- 58% find it easy to get through to this surgery by phone compared with a CCG average of 52.3% and a national average of 74.4%.
- 81.1% find the receptionists at this surgery helpful compared with a CCG average of 79.2% and a national average of 86.9%.
- 48.3% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 54.6% and a national average of 60.5%.
- 81.4% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 82.2% and a national average of 85.4%.
- 90.7% say the last appointment they got was convenient compared with a CCG average of 91.6% and a national average of 91.8%.
- 67.3% describe their experience of making an appointment as good compared with a CCG average of 62.4% and a national average of 73.8%.
- 75.1% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 58% and a national average of 65.2%.
- 59.1% feel they don't normally have to wait too long to be seen compared with a CCG average of 54.9% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 12 comment cards which were all positive about the standard of care received. Patients particularly mentioned the availability of emergency appointments when needed and that patients had access to these.

Grove House Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Grove House Practice

Grove House Practice is located in Runcorn, Cheshire and falls within the Halton Clinical Commissioning Group. The practice is run by six GP partners, supported by one salaried GP, two nurse prescribers, a practice nurse and a health care assistant. The practice is also a training practice hosting GP registrars and fourth year medical students. The practice has approximately 10, 500 patients. The clinical team is made up of five female GPs, 1 male GP and one male practice nurse.

The practice administrative support comprises 27 staff members, led by the practice deputy manager and the business manager. The practice premises are a purpose built facility which is shared by another GP practice. Other community clinicians are also based within the building, such as health visitors and community nursing teams.

The practice is open from 8.15am to 6.30pm on Mondays and Tuesdays of each week. From Wednesday to Friday, the practice is open from 7am to 6.30pm, with a further extended hours surgery on Thursday evenings when the practice is open until 8pm. The practice provides services under a PMS contract.

The practice does not provide out of hours services. Out of hours services are provided by a separate service, Urgent Care 24 (UC24). From October 2015, patients will ring the NHS 111 service first before being diverted by 111 to the out of hours provider.

Appointments can be booked on-line, by phone or in person. The practice has a rate of approximately 42% of appointments being booked on-line. There are telephone consultations available each day. The practice has recently begun to trial the availability of 'e-consulting', which is a system whereby patients can email the on-call GP, giving symptoms or details of their illness and the GP will respond to the patient on that day. GPs offer home visits to those patients with higher dependency needs who would not be able to visit the surgery themselves.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?

Detailed findings

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 September 2015. During our visit we spoke with a range of staff including the GP partners, the advanced nurse prescriber, the practice nurse, the business manager and deputy practice manager. We spoke with three patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

We noted some particularly good examples of incident reporting, recording, review and sharing of learning. A none medical incident involving a patient was recorded where the practice had checked with the Health and Safety Executive as to whether there was a requirement to submit a RIDDOR report. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These regulations require employers, and those in control of premises to report specified workplace incidents. We found the provider had acted correctly and took all reasonable steps to prevent the incident re-occurring.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe. Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. We saw that policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a GP lead for safeguarding, and a deputy who made themselves accessible to all staff. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. We saw several examples of the practice acting on its safeguarding responsibilities, which had positively impacted on the safety of children subject to a safeguarding plan. At times this had required GPs at the practice to challenge the decisions of safeguarding boards when locally acquired information could impact on safeguarding arrangements.

A notice was displayed in the waiting room, advising patients that nurses and the health care assistant would act as chaperones, if required. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.

Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits

Good

Are services safe?

were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw that deputising arrangements in the practice meant that staff absences could be managed successfully without adverse impact on the safety and welfare of other workers and patients.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The use of the system had recently been reviewed to ensure staff would always go and speak to GPs directly when information to be shared was important. We saw that clear guidance had been issued to staff on when it was appropriate to use instant messaging.

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

Defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

We saw several examples of how the practice had carried out more extensive health needs assessments. This required working with external partners within the health care community, to bring about effective treatment and more permanent, positive health outcomes for patients. For example, the practice had worked with a social care in practice (SCIP) worker to initiate a package of social care for a patient. Once in place, this resulted in a significant reduction of unplanned hospital admissions for the patients. Other examples included the GP and SCIP worker providing support to a homeless patient who was re-housed more quickly which contributed significantly to their health conditions being stabilised. We also saw an example of how GPs working with the SCIP worker had prevented a patient who had experienced a poorly managed discharge from hospital, having to return to hospital. The practice were able to show us how approximately 20 patients had been provided with more holistic care, treatment and support that provided more positive overall outcomes for patients.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework(QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 93.9% of the total number of points available, with 4.1% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013-14 QOF results showed;

Performance for diabetes related indicators was lower (other than in one area), than the national average. The practice had a plan in place to increase scores for management of diabetes patients. We saw that responsibility for this had transferred from a previous practice nurse to one of the advanced nurse practitioners. The newly recruited male practice nurse was undergoing training in the management of diabetes and when competent in this area, would be used to offer patients a choice of clinician when attending these appointments.

The practice had good results in relation to support and management of patients with mental health conditions including dementia. QOF figures from 2013-14 when viewed alongside evidence of interventions by GPs and practice nurses, supported the view that the practice placed sufficient priority and resource on the care of patients experiencing poor mental health.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been two clinical audits completed in the last two years, where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, the lead practice nurse prescriber kept a record of all cervical screening conducted at the practice and reviewed the numbers of inadequate screenings, checking for any common causes. Information was shared with other nurses in the practice, and at meetings of nurses across the CCG area. This nurse was also a mentor on this subject and shared best practice and mentored other nurses within the local area.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The practice was a training practice hosting GP registrars and fourth year medical students. We saw that strong mentoring and support arrangements were in place for students.

Good

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Where data showed the practice could improve on positive scores for patient satisfaction, we saw plans in place to address this. For example, GPs worked on a 'buddy' system within the practice to cover each other, giving improvements to continuity of care; typically patients would see either their named GP or a designated buddy GP.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 78.96%, which was comparable to the national average of 81.88%. The practice sent humorous birthday cards to all female patients aged 25 to highlight that they would be invited to attend for cervical screening. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 97.4%% to 99.1% and five year olds from 94.6% to 99.1%. Flu vaccination rates for the over 65s were 75.37%, and at risk groups 59.22%. These were also above national averages, which were 73.24% and 52.29% respectively. However, the practice had taken steps to increase uptake rates further, for example, sending a humorous birthday card to all patients on their 65th birthday, highlighting that they were eligible for Flu vaccination, and how they could book this with the practice.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. The practice had produced a twelve page booklet on men's health, covering the symptoms that are often warning signs that men should seek medical help for, for example, in relation to

Good

Are services effective?

(for example, treatment is effective)

prostrate health. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice had the facility for patients to monitor blood pressure remotely and used this information in the planning of treatment of chronic diseases.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 12 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with three members of the Patient Participation Group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 90.2% and national average of 86.6%.
- 87.9% said the GP gave them enough time compared to the CCG average of 88.7% and national average of 86.8%.
- 95.1% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.1% and national average of 95.3%
- 95.7% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%.
- 81% of patients said they found the receptionists at the practice helpful compared to the CCG average of 79.2% and national average of 86.9%.

The practice had taken steps to increase scores in relation to levels of patient satisfaction; all reception staff had enrolled on and either completed or were near completion, of a recognised customer services skills course. GPs had adopted a buddying system, which meant that patients would typically see one of two named GPs, improving patient continuity of care.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. We saw several examples of how clinicians at the practice had ensured patients and their carers were given every opportunity to choose how and when they would and could receive treatment. This could be done with the support of a SCIP worker were required.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice was one of the first in the country to use the services of a Well-being Officer. The purpose of the Wellbeing Officer is to empower people and communities to achieve happier, healthier and longer lives. This is achieved by the Wellbeing organisation educating professionals and the public, and delivering evidence based interventions that increase the feeling of wellbeing

Good

Are services caring?

of patients and communities as a whole. The Well-being officer visits the practice on a weekly basis, spending time in the reception and patient waiting areas so patients can approach the officer directly. Between November 2012 and August 2015, 123 patients had accessed the services of the Wellbeing Officer for the practice. Feedback from those patients indicated that this scheme had been successful for them in a number of ways, for example:

- 59.6% of patients reported a reduction in their depression symptoms
- 48.9% of patients showed an improvement in self-reported health status
- 66.1% of patients reported an improvement in their well-being.

The practice's computer system alerted GPs if a patient was also a carer. These patients were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

We saw several examples of care and support for patients, which included support of their families and carers. Where patients were required to make difficult decisions about how they moved forward with a health condition, they were offered access to educational material and information on what the outcome of their health condition could be. This included patients and families of those people diagnosed as being terminally ill. We saw how GPs worked with other stakeholders to deliver the best possible care with the highest levels of inclusion, understanding, compassion and dignity. GPs provided support to the families of these patients, and worked to ensure that they understood how a person's care pathway would progress. The practice used a buddy system utilising the six GPs at the practice so patients were familiar with those GPs they saw in consultations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;

- The practice offered a three 'Early Bird Clinics' from 7.00am on Wednesday, Thursday and Friday morning and was open until 8.00pm on Thursday of each week.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- The practice had recently recruited a male nurse to join the nursing team. This was a done with a view to increasing engagement with all male patients who didn't attend the surgery regularly. Flu season clinics were being used to raise awareness of other men's health issues, for example, prostate health. Initial figures showed attendance of appointments with the male nurse by male patients was good. It was too early to say whether this represented an increase in male attendance at the practice, or whether it was effective in providing sufficient early intervention to identify and address male health problems.
- There were disabled facilities, hearing loop and translation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when people find it hard to use or access services. For example, the practice had opened up all appointments to on-line booking. The rate of on-line appointment booking had risen to 42%. This had been done to address frustrations of patients who couldn't get through to the practice by phone in the mornings.

The practice was involved in three pilots funded by the Prime Minister's Challenge Fund, to increase access to GP services for patients, and patient access to other services that can help people stay well. In the first pilot, the practice had just started to deliver 'e-consulting', which was accessible via the practice website. The second pilot was described as 'Patient Connect', a scheme which had involved the building of a matrix of over 600 voluntary groups and organisations that can offer help, advice and support to patients on any number of health and social care issues, such as the social isolation of patients. The effect of this pilot was that patients could be directed to other resources for matters that related to health and well-being, as opposed to making their GP practice the 'first port of call'. The results on how successful this pilot was proving to be were not available at the time of our inspection.

The third pilot was on working more closely with community pharmacies, including the delivery of asthma education in schools and the effective use of inhalers, greater support through pharmacies of COPD patients, BP monitoring of patients, atrial fibrillation screening and management of minor ailments through pharmacies. The practice had produced a comprehensive guidance booklet on minor ailments which had been shared with the CCG and which other practices had adopted. The practice leaders were clear that the future success of the practice was to be invested in other services, voluntary or otherwise, and was key to ensuring that patients' needs were fully met. Again, results on how succesful this pilot had been were not yet available.

The practice was innovative in the way it worked to connect patients with other organisations, for example, by using a text system to direct patients to services they would find useful. The practice used IT extensively to meet patient demand safely. We saw that the practice used Met Office forecasts, for example, for cold weather warnings, to plan for and meet increased demands on the service.

Access to the service

The practice is open from 8.15am to 6.30pm on Mondays and Tuesdays of each week. From Wednesday to Friday, the practice is open from 7am to 6.30pm, with a further extended hours surgery on Thursday evenings when the practice is open until 8pm. Appointments were from 8.20am or 7.10am on early morning surgeries and ran throughout the day. The practice did not close during the lunch time period, although appointments during the 90 minute period from 12pm to 1.30pm were delivered by the on call GP for that day and the advanced nurse practitioners. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments were also available for people that needed them. The last pre-bookable appointment for each day was at 10 minutes before the advertised closing time of the practice.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and some national averages. People we spoke to on the day were able to get appointments when they needed them. For example:

- 75.3% of patients were satisfied with the practice's opening hours compared to the CCG average of 73.8% and national average of 75.7%.
- 58.1% patients said they could get through easily to the surgery by phone compared to the CCG average of 52.3% and national average of 74.4%.
- 67.3% patients described their experience of making an appointment as good compared to the CCG average of 62.4% and national average of 73.8%.
- 75.1% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 58% and national average of 65.2%.

The practice had taken some measures to increase satisfaction scores in relation to access to GP services. We saw how the practice had opened up all pre-bookable appointments to on-line booking. This had resulted in an increase in patients booking appointments in this way. The latest figures available from the practice showed that 42% of appointments were now being booked on line. This had also helped reduce telephone traffic, making it easier for patients with non-routine queries to speak to the practice staff.

The nursing team also offered early morning appointments, with one of the nurses being an advanced nurse prescriber. The appointment of a male nurse had also helped improve access to services for male patients. Some initial data available to the practice appeared to show an increase in the number of male patients attending the practice, although more time would be needed to confirm this. Initial results showed that in June and July of 2015, more than 50% of appointments with the male nurse, were with male patients, and in August 48.8% of appointments were with male patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system for example in the patient information leaflet and in posters displayed in the patient waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at all complaints received in the last 12 months and found that all had been handled in line with the practice complaints policy. We particularly noted that all complaints, whether formal or informal, were recorded and responded to. Complaints were discussed at practice meetings and reviewed by all staff members concerned to see if things could have been done differently, and if it would have changed the patient's experience at the practice. We saw that lessons were learnt from concerns and complaints and action was taken to improve the quality of care and patient experience of the practice.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff knew and understood the values of the practice and displayed behaviours that supported those values. An effective strategy and supporting business plans were in place which reflected the vision and values. These documents were regularly reviewed and updated. The lead partner was able to demonstrate how the recruitment of clinicians had supported the vision of the practice.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

We saw that comprehensive information on the performance of the practice was produced and shared. For example the Business Manager produced monthly budget update reports and spending forecasts. These were viewed alongside any other data that measured performance, such as immunisation uptake rates and overall QOF outcomes.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable. The partners encouraged a culture of openness and honesty amongst all staff.

Administrative staff were led and supported by a business manager and a practice manager. All staff we spoke with told us they felt appreciated, valued and that their contribution towards the success of the practice was recognised.

Staff told us that regular team meetings were held. For example, there were weekly nurses meetings, daily 30 minute GP meetings and weekly practice meetings for admin staff. These were used to share and exchange information but also as opportunities for short shared learning sessions. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, felt confident in doing so and felt supported if they did. The practice had an annual development day, which gave all staff time away from their desks to think about their own development and that of the practice. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, members of the PPG contributed to ideas on how the practice could actively and effectively encourage working age men to visit the practice more regularly to attend health checks or discuss men's health issues. The practice took the decision to recruit a male nurse to work full time at the practice, increasing access for male patients.

The practice had also gathered feedback from staff through an annual staff survey, through staff development days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged, commenting that they felt their contribution towards the success of the practice was recognised by partners and managers.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The practice also responded constructively to issues raised by clinical staff that impacted on their daily duties. These were often around working with secondary care providers, for example local hospitals and clinics. To address this in a positive way, the practice invited the Head of Partnerships and Development for Warrington and Halton Hospitals to the practice to discuss these issues. Points raised included insufficient discharge information, GPs having to chase up results on investigations ordered by hospital physicians, delays in receiving some outpatient letters and letters from clinics, and delays for patients waiting for prescriptions from out-patient clinics. These points were fed back to the local hospitals and clinics and the practice staff were confident that each point would be addressed. Staff also had the opportunity to discuss which services they thought would offer the most benefit to patients, if they were available in the community.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of several local pilot schemes to improve outcomes for patients in the area. We saw how the success of a 'market day' for older patients, was used as a driver to repeat these market days for other patient groups such as families children and younger patients. Nurses were using the planned flu clinics to raise awareness of the market day, posters were being ordered and staff were engaged in raising awareness to those patients that would find the event useful.

The practice leads were developing the texting service, used to remind patients of their appointment time, to deliver other messages at key times – for example, promoting the services of the recently recruited male nurse. The latest trial was the ideal of e-consulting for patients. This involved patients emailing the practice about their symptoms and a GP would respond on the day. Along with several other nationally and locally funded pilots, the practice demonstrated that they were willing to adapt their services to fit the needs of the population, whilst maximising their existing resource.